Intermediary FMU personal application form

PPP HEALTHCARE

Enquiry date: | Name of intermediary:

Agent name: | Agency number: FQ648

Your personal reference number:

Please quote this if you call or write to us

Expatriate Insurance Services/UK Health and Life Insurance Services. Fax 01379643098

Please complete this form in block capitals

1 Your personal details (main policyholder)

Full name (including title)

Address

Postcode:

Contact tel no.

Date of birth

Gender

Height

Weight

Smoker Yes ☐ No ☐

2 Details of all other persons to be included in the policy

18 YEARS OLD and OVER. Please ensure all the details below are correct.

Full name (including title)	Relationship to policyholder	Date of birth	Gender (M / F)	Weight	Height	Smoker Y / N
		/ /				
		/ /				
		/ /				
		/ /				

UNDER 18 YEARS OLD.

Full name (including title)	Relationship to policyholder	Date of birth	Gender (M / F)
		/ /	
		/ /	
		/ /	
		/ /	

3 Your chosen level of cover

Note: *Prices are reviewed 1 April and 1 October. If your 'quotation' changes outside these dates, we will notify you in writing. Your quoted price may also change if you have moved, if anyone requiring cover has had a birthday since you first contacted us or due to your medical history declaration. The price is based on a 12 month period of cover. You will receive details of how to renew your cover prior to the end of this 12 month period.*

Please indicate which plan you are applying for

Plan	6 (6 Week Option)	Choice (no claims discount)	6 Choice (combination of Choice and 6)
☐ Premier Plus	N/A	☐	N/A
☐ Premier	☐	☐	☐
☐ Ideal	☐	☐	☐
☐ Key	☐	☐	☐
☐ Assure	☐	☐	☐
☐ IHC (Gold)	☐	N/A	N/A
☐ IHC (Silver)	☐	N/A	N/A
☐ IHC (Bronze)	☐	N/A	N/A

Premium Quoted £

Level of excess required: ☐ £0 ☐ £100 ☐ £200 ☐ £500

Level of hospital cover required: ☐ Cover level one ☐ Cover level two

4 Medical history declaration

Important: Please answer all the questions in full and to the best of your knowledge and belief. If you have any doubts whether something may influence how we deal with your application (we call these material facts), you should include it as your policy may be invalid entirely if you fail to disclose any material facts. If for any reason you do not answer a question, we shall take that as meaning you have nothing to disclose. You do not need to tell us about any genetic test results. Please note, once you have joined we do not pay for treatment of any medical condition (or treatment of any medical condition arising from or associated with such a medical condition) which you already had when you joined and which you should have told us about but did not tell us at all or did not tell us everything unless you have declared it and we have not excluded it. This includes any such medical condition(s) or symptoms, whether or not being treated and any previous medical condition(s) which recurs of which you should reasonably have known about even if you had not consulted a doctor.

(Please note that for instances where we do contact your GP for further medical information the GP may make a small charge for preparing the report. AXA PPP healthcare will be pleased to make a contribution of up to £20 (directly to the GP) for each patient reported on. Should the fee be in excess of this sum you will be responsible for the balance.)

Please complete this section for all individuals. Please check whether the names of all those persons to be declared for each question are correct as printed next to the 'Yes' and 'No' boxes, then give further details below. If you need to declare further people or information please use an additional sheet of paper.

Hospital/Specialist Treatment – Has anyone consulted with a specialist, been admitted to hospital or nursing home, or suffered from intermittent or recurrent illness during the last five years?

Please tick No ☐ Yes ☐ If yes, please complete the following:

Name of Patient(s)	Nature of illness/disability and treatment received	Period of disability/treatment Month Year Duration	Present state of health in this respect (please be specific)

General Practitioner Treatment – Has anyone attended a GP in the past year?

Please tick No ☐ Yes ☐ If yes, please complete in full the following (to include full details of all minor and childhood conditions):

Name of Patient(s)	Nature of illness/disability and treatment received	Period of disability/treatment Month Year Duration	Present state of health in this respect (please be specific)

Other Treatment – Does anyone have any medical condition, disability or health problem, not mentioned above, whether or not a doctor has been consulted, for example, gynaecological or menstrual problems, complications of pregnancy, signs or symptoms of varicose veins, back trouble, joint disorders, joint replacements, foot problems (eg bunions), indigestion or bowel problems, abdominal pain, skin problems, allergies, anxiety, depression or other psychiatric problems, trouble with heart, limbs, ears, eyes, urination etc. and is there any other information which you should, in good faith, disclose?

Please tick No ☐ Yes ☐ If yes, please complete the following:

Name of Patient(s)	Nature of illness/disability and treatment received	Period of disability/treatment Month Year Duration	Present state of health in this respect (please be specific)

Additional medical information (If you need more space please use a separate piece of paper. Sign, date it and attach it to the form)

I declare that to the best of my knowledge and belief the statements made on this form are true and correct. I acknowledge that the acceptance of my application shall be on the basis of these statements and that I and my family members included in this policy shall be bound by the terms of the policy which I shall read when I receive my policy details. I understand that you will send all correspondence about this policy to the main policyholder unless I write to tell you otherwise. I have indicated the policy and method of payment I would like.

Please note: If any of the information you have given us changes before we have told you that your policy has begun, you must tell us in writing at once.

We advise you to keep a record of all information you give us in connection with this application, including any letter(s) you send us in connection with it. If you would like a copy of this application, please let us know within three months. We may turn down an application if we discover that the information you give us is not sufficiently true, accurate and complete so as to present to us fairly the risk we are taking on. We reserve the right to decline your application.

Once you have joined we do not pay for treatment of any medical condition (or treatment of any medical conditions arising from or associated with such a medical condition) which you already had when you joined and which you should have told us about but did not tell us at all or did not tell us everything, unless you have declared it and we have not excluded it. This includes any such medical condition(s) or symptoms, whether being treated or not.

You and we are allowed to choose which law will govern this policy. Because we are in the United Kingdom we only sell policies that are governed by the Law of England and Wales, so that is the law that applies.

Signature: ✗ Date: ✗

Your 14 day money-back guarantee

When you receive your membership documents, you will have 14 days in which to ensure you are entirely satisfied with your cover. If, for any reason, you do not wish to proceed, you may cancel your membership at any time during this period and owe nothing as long as you have not made a claim. Any money which you have paid or which we have collected will be returned to you.

Other information

Data Protection Act – you will see this sign where we ask you to give personal information.

Please make sure that you either show this statement to anyone covered by this policy, or inform them of its contents before you return this form.

To set up and administer your policy AXA PPP healthcare limited will hold and use information about you and any family members covered by your policy, supplied by you, those family members, medical providers or your employer. Please ensure that you only provide us with sensitive personal information, such as health information, about other people with their agreement. When you give us this information we will take this as confirmation that you have consent to do so.

We may send personal and sensitive personal information in confidence for processing by other companies and intermediaries, including those located outside the European Economic Area.

As you act on behalf of any family member covered by this policy, we send correspondence about the policy, including claims correspondence, to you unless we are advised to do otherwise.

By signing and returning this form you indicate that you have authority to give consent on behalf of any family members covered by your policy and on your own and their behalf you consent to the use of personal information in the ways described above.

We may disclose information about anyone covered by your policy where there is a legal requirement for us to do so or in circumstances when it would help us prevent or investigate fraud or improper claims.

AXA PPP healthcare limited may contact you with details of its other products and services. We may also share some of your details with other AXA Group companies or other carefully selected companies based within the European Economic Area to enable them to contact you with details of and, if appropriate administer, their products and services. We may contact you by post, telephone, or electronically if appropriate. By signing and returning this form you will be consenting to these uses to enable you to receive marketing information from AXA PPP healthcare as well as from other AXA UK Group companies and/or third party companies unless you tick the box to indicate that you do not consent ☐.

You may change your mind at any time by writing to the address on the back of the Membership Handbook.

5 How to pay

You can choose to pay for your cover either annually, quarterly or monthly, it's up to you. Simply tick one of the three boxes below to indicate your choice, then decide how you would like to pay. **Important:** Please note that if you opt to pay by cheque, you cannot choose the monthly payment option and should tick either the annual or quarterly payment box below.

How often would you like to pay?: Annually ☐ Quarterly ☐ Monthly ☐

How would you like to pay: 1 Direct Debit (complete the mandate below ensuring that you sign and date it)
2 Credit card (please complete section 6)
3 Cheque (please make cheques payable to AXA PPP healthcare Ltd and enclose it with this application)

Instruction to your Bank or Building Society to pay by Direct Debit

Please fill in the whole form **(including the official use box if appropriate)** and send to:
AXA PPP healthcare, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL.

Name and full postal address of your Bank or Building Society

To The Manager: Bank/Building Society

Branch address:

Postcode:

Name(s) of Account Holder(s)

Bank/Building Society account number

Branch Sort Code

Reference Number (AXA PPP healthcare membership no.)

Originator's identification number

9	9	1	3	3	3

DIRECT Debit

For AXA PPP healthcare official use only

This is not part of the instruction to your Bank or Building Society

Please complete this box if you are paying on behalf of the Policyholder.

Name and address of account holder:

Telephone no:

Policyholder's name:

Instruction to your Bank or Building Society

Please pay AXA PPP healthcare Direct Debits from the account detailed in this Instruction, subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with AXA PPP healthcare and, if so, details will be passed electronically to my Bank/Building Society.

Signature: ✗ Date: ✗

Banks and Building Societies may not accept Direct Debit Instructions for some types of account.

6 Credit card payment authority

To AXA PPP healthcare, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL. I authorise you, until further notice to you, to charge my Mastercard/Visa account unspecified amounts in respect of premiums as and when these become due until this Instruction is countermanded by my giving notice in writing to AXA PPP healthcare at the address above. (AXA PPP healthcare will give you at least 14 days notice of any premium increase.)

Mastercard / Visa account number

Expiry date

Membership number

Surname Mr/Mrs/Miss/Ms: (as on credit card)

Forenames:
(as on credit card)

Address:

Postcode:

Signature: ✗ Date: ✗

Checklist

Tick the appropriate boxes in this section

Have you:

1. ☐ **Checked your personal details are correct (including telephone number)?** (section 1)
2. ☐ **Checked and/or completed the details of the additional persons to be included?** (section 2)
3. ☐ **Selected your chosen level of cover?** (section 3)
4. ☐ **Completed the medical history declaration?** (section 4)
5. ☐ **Signed and dated the policyholder declaration?** (section 4)
6. ☐ **Chosen method of payment?** (section 5)
7. ☐ **Signed and dated the Direct Debit form?** (section 5) – if applicable
8. ☐ **Completed the credit card authorisation and signed it?** (section 6) – if applicable
9. ☐ **Enclosed a cheque?** – if applicable

Now send the form to:

New Business Administration, AXA PPP healthcare, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL

Or use the envelope provided.